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Dignity in Iranian cancer patients: a qualitative approach

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ABSTRACT

With some chronic illnesses, such as cancer, dignity can be damaged. Twenty consenting and volunteering males and females were chosen to take part in a study on dignity in Iranian cancer patients. Semi-structured interviews were conducted using directed content analysis based on Chochinov's study on dignity. Interviews were audiotaped and transcribed verbatim. The findings of the interviews were coded as open and axial and a constant comparison technique was used. The results showed four main components associated with Iranian patients' dignity, including 1 – illness-related concerns, 2 – patients' God-image, 3 – Social Dignity Inventory, 4 – family, and financial-related issues. Although similar findings in Chochinov's research have been identified, the results of this study suggest that cross-cultural differences require a culturally sensitive approach to Chochinov's dignity model for the Iranian community.

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Introduction

The experience of chronic illness, such as cancer, involves all aspects of a person's life. The suffering encompasses the physical, psychological, social, and spiritual aspects of the patient's life. Most people refer to cancer as a life-changing experience. The changes that result from cancer include profound changes in a patient's sense of self, physical appearance, family relationships, and relationship with religion or God.

One of the comprehensive models of care, which encompasses all aspects of a patient's life, is associated with the patient's dignity (Chochinov, Hack, Hassard, et al., 2002). Novak (1998) states that the word dignity originates from the Latin word dignitas which means the feeling of worth and pride. From the religious perspective, a human feels dignified because of some God-given potentials such as the power of reason, self-awareness, and free-will (Ali, 2015).

Theoretically, dignity can be understood in a humanistic psychological perspective. Rogers (1959) believed that people possess inherent goodness. He stated that although humans tend to be self-actualised, they might face many obstacles to self-actualisation. He suggested that one of these very important obstacles is related to a person's interaction with others which develops an individual's social-self. The social-self consists of a

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person's perception of the regard significant others, such as parents and siblings, hold towards the self. The self has been evaluated through social judgements in some areas, such as behavioural conduct and physical appearance. Here, a high or low sense of dignity can refer to a set of positive or negative images that a person holds towards the self which are rooted in self-evaluative judgements over the stages of lifespan development. Similarly, Maslow (2013, p. 119) placed the esteem needs in the fourth stage of the hierarchy which encompasses confidence, strength, self-belief, personal, and social acceptance and respect from others. Maslow (2013, p. 119) stated that some negative labels a person receives from others could activate some defence mechanisms to protect one's sense of dignity.

Empirically, Chochinov and his colleagues have carried out continued research on the concept of dignity (Chochinov, 2002; Chochinov et al., 2005; Chochinov, Hack, Hassard, et al., 2002; Chochinov, Hack, McClement, et al., 2002). He offered findings about how some experiences undermine or support one's sense of dignity during the course of suffering from cancer. Using qualitative research, Chochinov, Hack, Hassard, et al. (2002) applied a semi-structured interview to explore 50 cancer patients' sense of dignity. Each patient's feeling of dignity was explored by asking the following questions: (1) In terms of your own illness experience, how do you define the term dignity? (2) What supports your sense of dignity? (3) What undermines your sense of dignity? (4) Are there specific experiences you can recall in which your dignity was compromised? (5) Are there specific experiences you can recall in which your dignity was supported? (6) What would have to happen in your life for you to feel that you no longer had a sense of dignity? (7) Some people feel that life without dignity is a life no longer worth living. How do you feel about that? (8) Do you believe that dignity is something you hold within you, and/or is it something that can be given or taken away by others (Chochinov, Hack, Hassard, et al., 2002).

The themes and sub-themes extracted from the analysis are as follows. Illness-related concerns, within the theme, where several important sub-themes emerged, including the level of independence and symptom distress. Level of independence includes the sub-themes, cognitive acuity, and functional capacity. Symptom distress includes the sub-themes, physical distress, and psychological distress. The second major theme is a dignity-conserving repertoire which includes several important sub-themes: continuity of self, role preservation, generativity/legacy, maintenance of pride, hopefulness, autonomy/control, acceptance, and resilience/fighting spirit. Dignity-conserving practices include living "in the moment", maintaining normalcy and seeking spiritual comfort. The third major theme is the Social Dignity Inventory which includes privacy boundaries, social support, care tenor, a burden to others, and aftermath concerns (Chochinov, Hack, Hassard, et al., 2002).

Ten key questions were used to guide an interview creating a written legacy document that the person can share with significant others (Chochinov & McKeen, 2011). Several studies have shown that Dignity Therapy (DT) is acceptable and applicable in a variety of cultures. For example, the study of Houmann et al. (2010) showed that DT is acceptable, relevant, and manageable in Danish culture. In Japan, the feasibility of providing DT for terminally ill cancer patients has been studied. The results showed that although some patients refused to participate in DT because it makes them think about death, it might be encouraging for some who hope to leave a legacy (Akechi et al., 2012).

Although DT at the end of life forms this effective treatment, Chochinov (2002) implemented some other therapeutic interventions for the explored themes and sub-themes. For example, regarding the feeling of a burden to others, the therapist simply asks the patient: Do you worry about being a burden to others? If so, to whom and in what ways? Then the basic assertion technique offered allows the patient to speak clearly about whom they believe they will be a burden to.

Several studies were conducted regarding Iranian patients' perception of dignity (Ebrahimi et al., 2012; Hosseini et al., 2017). For example, Cheraghi et al. (2015) explored the Iranian sense of dignity using qualitative research. They found three main themes and related sub-themes regarding the meaning of preserving patients' dignity. The necessity of preserving the innate human dignity is the first main theme and it has two sub-themes: respect for the intrinsic equality of all humans and treating the patient as a valued person, not an object. Service based on love and kindness was the second theme which included two sub-themes: being with the patient and inspiring the sense of being accepted and loved. Dignifying and transcendental professional service was the third main theme which consisted of two sub-themes: professional commitment to uphold patients' rights and enlightened practice.

Attention to cultural differences is of particular importance in scientific studies. Cultures shape different conceptions of the self. They set a predefined framework to let people see themselves as good or bad in a situation (Tsai et al., 2001). The self has been viewed as an independent, autonomous, self-contained entity in North American and Western European cultures (Markus & Kitayama, 1994). This individualist culture encourages individuals to view themselves as independently functioning agents which are positively correlated with self-esteem (Heine & Lehman, 2004). On the other hand, many Asian, African, and Hispanic collectivistic cultures are characterised by an interdependence cultural framework (Triandis, 1994). For example, the Iranian collectivistic culture encourages people to view themselves as not separated from others and the surrounding social context. The aim of this study is thus to explore the concept of dignity among Iranian cancer patients. The Chochinov (2002) study on the dignity of Canadian cancer patients would benefit from further exploration of the meaning of dignity in Iranian culture. It seems that differences in cultural and religious beliefs or practices of Iranian cancer patients influence their perception of dignity. As a result, the experiences of Iranian patients can show how their undermined sense of dignity might have some treatment implications.

Method

The purpose of the present paper was to explore the perception of Iranian cancer patients about their sense of dignity. To explore the patients' sense of dignity, a semi-structured interview was applied. The interviews were recorded and then transcribed verbatim. The documentation was coded as open and axial by using a directed content analysis as manifest contents. The initial coding scheme and interview questions were developed from Chochinov's (2002) study. The directed approach of content analysis is guided by a more structured process than the conventional approach (Hickey & Kipping, 1996; Hsieh & Shannon, 2005). Researchers begin to identify main concepts or variables as initial coding categories using the existing theory or prior research (Potter & Levine-Donnerstein,1999). Next, operational definitions for each category are determined using the theory.

Participants

The outpatient Palliative Care Center of Razavi Hospital advertised the dignity research programme on the hospital website asking for research subjects. The inclusion criteria included all over 20-year-old men and women diagnosed with cancer which is generic and includes different forms of cancer. Of 30 patients registered, 22 were women and eight were men. The exclusion criteria were designed to exclude those with major depression, personality disorders, dementia, and a life expectancy of less than 6 months. Seven patients meeting the exclusion criteria were excluded. Twenty-three patients were given an introductory session to discuss what the dignity research programme is about, to find the equivalent word to the English "dignity" in Farsi and finally to obtain the informed consent. Three surviving female cancer patients chose not to continue the programme because they found it reminded them of dignity-diminishing experiences. The remaining 20 patients were interviewed with eight dignity questions developed from Chochinov's (2002) study.

Results

Twenty patients participated in the study, including 14 females and six males. Ten patients had been diagnosed with breast cancer, two patients with lymphoma, the others had been diagnosed with liver cancer, acute leukaemia, brain tumours, prostate cancer, and uterine cancer. Three patients had been diagnosed in the fourth stage of cancer. Demographic characteristics of participants are shown in Table 1.

Four major categories emerged from the qualitative analysis, including (1) illness-related concerns, (2) patients' God-image (3) Social Dignity Inventory (4) family and financial-related issues (Table 2). These categories refer to the experiences where patients' sense of dignity was undermined.

1. *Illness-related concerns*

Chochinov, Hack, Hassard, et al. (2002) conceptualised this category as concerns that undermine our sense of dignity which is derived from, or is related to, the illness itself. There are two themes in this category: physical distress and psychological distress.

Table 1. Demographic characteristics of participants.

Gender/N	Cancer type	Mean	SD	Age/N	Education/N	Occupation/N
10 Females	Breast cancer	10/5	5/9	Under 40(2)	3 Less than high school	11 Housekeepers
1 Female	Oral cancer			40 (4)	14 Diplomas	8 Employers
1 Male and 1 Female	Lymphoma			45–50 (8)	3 Masters and	1 Retired
2 Males	pancreatic cancer (end-stage)			50–55 (5)	above	
1 Female	Liver cancer			Over 55 (1)		
1 Male	Acute leukaemia (end-stage)					
1 Male	Brain tumour					
1 Male	Metastatic prostate (end-stage)					
1 Female	Uterine cancer					

Table 2. Themes and sub-themes of dignity in Iranian cancer patients.

1 – Illness-related concerns	2 – Patients' God-image	3 – Social Dignity Inventory	4 – Family and financial-related issues
1.1. Physical distress	2.1. Punishing God	3.1. Disclosure of cancer diagnosis	4.1. Privacy boundaries
1.1.2. Pain complaints	2.2. God is a taker	3.2. I hate pity	4.1.1. Parental enmeshment
1.2. Psychological distress	2.3. God is deaf	3.3. Feeling of being rejected	4.1.1.1. Patient's over-involvement in children decision-making
1.2.1. Fear of cancer recurrence	2.4. A blind God	3.4. People judge me negatively	4.1.1.2. Excessive worrying about children
1.2.2. Fear of a bad death	2.5. A strict God	3.5. Burden to others	4.1.1.3. Patient's over-involvement in doing the chores
1.2.3. Negative body-image			4.2. Financial-related issues
1.2.4. Medical uncertainty			4.2.1. Worrying about losing the job
1.2.5. Treatment far from hometown			4.2.2. Health insurance coverage
1.2.6. Tiring of length of treatment			

1.1. *Physical distress*

Chochinov and McKeen (2011) defined physical distress as symptom distress which refers to patients' experiences about their bodily sensations or concerns. The sub-theme of physical distress is pain complaints.

1.1.1. ***Pain complaints.*** A 40-year-old cancer patient answered the question, "what does dignity mean to you?" as: P: My right hand's nerves were damaged due to the surgery, it's like paralysis, and it is painful when I stretch my hands.

1.2. *Psychological distress*

Chochinov, Hack, Hassard, et al. (2002) defined this category as patients' depression, anxiety, and fear and other ways in which a patient responds to changing health circumstances, whether actual or threatened. This item for an Iranian cancer patient was experienced as: fear of cancer recurrence, fear of a bad death, negative body-image, medical uncertainty, treatment far from hometown and tiring of length of treatment.

1.2.1. ***Fear of cancer recurrence.*** A 50-year-old woman with breast cancer, after treatment, responded about her sense of dignity as follows:

> P: One thing I'm angry most about is related to my thoughts, when I have a headache, for example, I think my cancer has returned, the ache in my hand I feel, I say oh, my cancer is coming back.

1.2.2. ***Fear of a bad death.*** Some patients feared dying badly more than death. A 50-year-old patient was asked to describe her sense of dignity as follows:

> P: Honestly, I'm not afraid of death, I'm just worried about how I'm going to die. I wish to die with ease. You know, when I go back and think about how my treatment was painful, I say oh God please help me to die without pain.

1.2.3. ***Negative body-image.*** One 55-year-old woman with breast cancer described how she became undignified:

P: Well, after all these years I had survived cancer, something has remained unforgettable to me. For example, I cannot go to swimming pool. Once I went to a swimming pool with my sister, no one found out my breast removed but I was thinking myself they figured it out. I think it sounded like they were whispering to each other. I love swimming but no longer am willing to go there. Let me tell you about my husband, I invariably fear that my husband will find me different from other women.

1.2.4. ***Medical uncertainty.*** A woman with oral cancer describes how her sense of dignity was threatened after a surgery. When she was asked how she felt about her dignity after she underwent an operation she says:

P: when my surgeon wanted to remove cancer from my body, I asked him please tell me what will happen to me after the operation, my beauty is important to me? My surgeon didn't like to answer. After some days I found they removed my uvula, now I am unable to correctly pronounce some words. I think people look at me strangely. I really wanted my surgeon explained to me, this was my right.

1.2.5. ***Treatment far from hometown.*** In Iran many people travel far from their home to obtain medical treatment. A 44-year-old woman with breast cancer described her sense of dignity as follows:

Being far away from home and children is so difficult. I was a respected woman in my city, here, no one knows me and I have to take this long way far from home.

1.2.6. ***Tiring of length of treatment.*** Extended treatment continues for a long time after an initial cancer diagnosis and primary treatment. Many patients complained about the length of treatment. For example, a woman with breast cancer described how the length of treatment took her sense of dignity and made her tired.

P: my initial diagnosis was breast cancer, 14 of my lymph nodes were removed. Well, the cancer spread to my liver, and I took very strong medications. After a while, I realized that I was so weak that couldn't eat anything. I am tired, I said, "God, do me a favor, I don't have the patience to go and come anymore".

2. *Patients' God-image*

This category refers to the perception of Iranian cancer patients in terms of God, dignity, and cancer. This category consists of five sub-themes, including (1) punishing God; (2) God is a taker, (3) a deaf God, (4) a blind God, and (5) a strict God.

2.1. *Punishing God*

A 55-year-old male diagnosed with acute leukaemia described his sense of dignity as follows:

P: I know this cancer is from God
C: how?

P: I did a major sin in my youth. I'm sure God is punishing me; this cancer is the result of that Sin.

2.2. *God is a taker*

One patient when asked, do you believe that dignity is something you hold within you, and/or is it something that can be given or taken away by others, said:

P: A 45-year-old breast cancer patient replied: I have problems with God, he took my dignity, and my failure started a long time before my cancer. I have changed my relationship with God, for example, I do not pray anymore, I do not call him, I have nothing to do with him, sometimes I say to myself, did God create me? I am not sure, because if he created me, why he caused me intolerable suffering? I lost my husband, one year after my father died, I was really messed up, went to Karbala (Imam Hussein Holy Shrine), crying and speaking with God, oh God why this happened to me? When I came back from Karbala, I found I have got breast cancer.

2.3. *God is deaf*

Another 47-year-old breast cancer patient described her sense of dignity as:

P: As you know, at the age of 17, I was forced into an unwilling marriage with a depressed man. Before 17 I was not happy with my parents. After my husband committed suicide, my only hope was to raise my son. Actually he was my only man in the house; you know God took him as well.
C: what a sad story, you said God took him?
P: I think he is deaf, he never hears me, and he turned his back on me.

2.4. *A blind God*

A woman with breast cancer answered to the question what does dignity mean to you, as follows:

P: I don't understand what it means. I don't know what God is doing, I lost everything in a few years.
C: What is God doing?
P: I think God always says no, he can't see me, he is blind.

2.5. *A strict God*

A religious woman with breast cancer described how her sense of dignity has been undermined for years:

P: when my sister died of cancer, God took my two brothers afterwards. This really affected me.
C: Sometimes you talk to God?
P: Well, yes, I always try to know God with knowledge and logic. Honestly, I think he is very strict.

3. *Social Dignity Inventory*

Chochinov, Hack, Hassard, et al. (2002) defined the Social Dignity Inventory as social concerns or relationship dynamics that enhance or detract from a patient's sense of dignity. The emerged four-sub-themes include (1) fear of disclosure of cancer diagnosis; (2) I

hate pity, (3) feeling of being rejected, (4) people judge me negatively, and (5) burden to others.

3.1. *Disclosure of cancer diagnosis*

A 44-year-old breast cancer patient explained how her sense of dignity is undermined in her relationship with others:

P: I am a teacher, since I got cancer, I liked to withhold my diagnosis from others, and I live far from here, since I came here for treatment so I had not been in the city for a while. Many people became skeptical. They were asking about my absence and I lied to them, I told them I had a problem in my hand. Actually, you know, my husband is the manager of Telecommunication Company, he is so famous in the city, and I found an unknown sent a message to him about my cancer, he told my husband, look at your life and see what is your fault that God took your wife's health (patient is crying). Actually, I'm afraid of going to ceremonies, I lost my hair due to chemotherapy, I am sure they will search and question me why I lost my hair.

3.2. *I hate pity*

To hate pity was a repeated sub-theme throughout the interviews. Many patients experienced it or they hated experiencing it. Most of patients did not agree with diagnosis disclosure because they did not like to be pitied. When a woman with breast cancer was asked how she feels about her dignity, she replied as:

P: The only one who knew about my cancer was my mom, you know mom is the only person should know it. I hurt to meet people's pitying look. It has been for eight years when I go to a party, my relatives say, do you feel better? I hate to hear this word.

3.3. *Feeling of being rejected*

A feeling of being rejected by a 64-year-old breast cancer patient emerged when she was asked about her sense of dignity.

P: I remember that my relationship with my aunt was very good; once she borrowed some clothes from me, she didn't return them back at the time. When she discovered I got cancer, she sent my clothes back immediately. From her verbal and non-verbal cues, she wanted to send me this message, cancer is contagious. I am sure she returns my clothes because she fears of getting cancer.

3.4. *People judge me negatively*

In the interview with another 55-year-old breast cancer patient whose breast was removed with surgery, she complained about why she lost her dignity:

P: I tried to withhold my cancer diagnosis from my relatives. My relationship with my mother-in-law became complicated in particular. I could no longer keep my cancer a secret within the family. You know my mother-in-law is a strict religious woman and we are quite opposite. For example, I don't wear Hijab, I don't pray and I don't go to mosque. We were in a family party, she asked me about my cancer and I told her something about it. She said why you got cancer, of course, has a reason for what you did before.

C: what did she mean you did something before?

P: she meant because I am not a religious woman God gave me this cancer as a punishment.
C: you think that is true?
P: No, I don't. I believe God loves me.

3.5. *Burden to others*

A 39-year-old male, stage four pancreatic cancer patient responded to the question of what does dignity mean to you, as follows:

P: (Patient crying) oh God, never give a man cancer. I was the one who crushed the mountain 25 days ago, I fell off here, pain is killing me, you know I am a Muslim, I want my death and I am ok with it, I don't want to be a burden to my family, I am now a burden to them.

4. *Family and financial-related issues*

This category describes the patient–family relationships regarding a patient's dignity. Within this theme is a sub-theme including privacy boundaries (parental enmeshment), which consists of patient's over-involvement in their children's lives and decision-making, excessive worrying about their children, and patient's over-involvement in doing the household chores.

Privacy boundaries were conceptualised by Chochinov, Hack, Hassard, et al. (2002) and categorised by the Social Dignity Inventory which denotes the extent to which dignity can be affected by having one's environment violated during care or support. In the current research, with Iranian cancer patients, privacy boundaries emerged as a family issue with parental enmeshment which is conceptualised by Minuchin and Nichols (1998) where the boundaries between the members of a family are not clear.

4.1. *Privacy boundaries*

4.1.1. *Parental enmeshment.* Within parental enmeshment theme, three subthemes emerged including patient's over-involvement in children decision-making, excessive worrying about children, and patient's over-involvement in doing the chores.

4.1.1.1/2. *Patient's over-involvement in children decision-making and excessive worrying about children.* A 26-year-old male with Hodgkin's lymphoma described his sense of dignity as follows:

P: my parents think they can force me to do some things that I'm not interested, for example, every day, they make me to watch a spiritual TV program, because they feel I need it, but I hate it.

4.1.1.3. *Patient's over-involvement in doing the chores.* A woman with liver cancer described her sense of dignity as:

P: When I got cancer, my husband was so worry about my cancer. At first, I became so happy he cared about me, but when I came back home from the hospital, my family thought I feel better, so my husband and my daughter went away. Even under chemotherapy I did all the chores, you cannot believe it, they no longer care about me and my cancer. You know, they are used to someone like me who gives services at home.

4.2. *Financial-related issues*

This category also refers to the worry about losing their job or salary reduction due to the length of cancer treatment. Within this category, two sub-themes emerged including (1) worrying about losing their job, (2) health insurance coverage.

4.2.1/2. *Worrying about losing the job and health insurance coverage*

A low-wage earning male with acute leukaemia described his sense of dignity as follows:

> P: I am not able to afford to take time off without pay, I have 3 children, my insurance coverage is limited and I am really worrying about losing my job.

Discussion

The primary aim of the current paper was to explore the concept of dignity among Iranian cancer patients, and the secondary aim was to see how to expand Chochinov's dignity framework to an Iranian collectivist culture.

The results of this study showed some similarities and differences with Chochinov's (2002) study on dignity in Canadian culture. Both Canadian and Iranian patients found their sense of dignity was undermined in the areas of a burden to others, physical distress, medical uncertainty, pain complaints, and privacy boundaries. Similar areas in the two different cultures include physical distress, medical uncertainty, and pain complaints seem to be explained by intrinsic factors influencing the sense of dignity, as suggested by other research studies (Harcum & Rosen, 1990). Two exceptions to this were the areas of a burden to others and privacy boundaries.

However, there are some differences in the way Iranian and Canadian patients' dignity can be undermined. The differences between the two cultures could refer to extrinsic factors influencing a sense of dignity; Skinner (1971) suggested that the increase or decrease in the sense of dignity can be associated with receiving positive reinforcement and punishment. For example, the sub-theme feeling of being rejected emerged with a 64-year-old breast cancer patient which showed this difference. Although rewards and punishments are in both cultures, the manner people reward and punish might be culturally different.

The most notable difference between Canadian and Iranian patients regarding their sense of dignity is related to family issues which appear repeatedly in Iranian patients' interviews. The results of this study showed that privacy boundaries had been violated when the patients were overly involved in their children's lives. These patients experience excessive worrying about their children, while they are adult or even married. Although collectivism is characterised by the definition of self in terms of relationships, emphasis on social cohesion and harmony, and the value of family integrity, today Iranian society is less accepting of this high degree of family enmeshment.

The patient over-involvement in children lives, according to Minuchin and Nichols (1998), is a reflection of a dysfunctional family system which is characterised by diffuse or rigid boundaries and roles. Diffuse boundaries allow intrusions upon a subsystem by other systems to the degree that inhibits functioning and does not allow sufficient autonomy. Our interviews with Iranian cancer patients showed that most of the patients' family structures are dysfunctional. Role displacement was evident in the spouse and also in the

parental sub-systems, which represented a role and boundary diffusion between the sub-systems. Eight of the ten breast cancer patients complained of being over-involved in doing the chores before and after treatment. Iranian females are encouraged culturally and religiously to be caretakers of the homes, whose main responsibilities are to give birth, rear the children, and to do the chores.

On the other hand, men are considered to be breadwinners. These culturally and religiously learned rules means that some Iranian female cancer patients continue to do the chores, even though they have cancer. In addition to this, patients' were unable to challenge the family system and there are no accommodations in the Iranian health care system to assist patients who are caretakers of the homes.

The results of the current study showed that there were some similarities between Iranians and Canadians regarding their social dignity. Both Chochinov's (2002) and current studies addressed how patients' dignity was undermined by social interactions. However, this present study and Chochinov's studies both demonstrated burden to others has cross-cultural resonance, whereas Iranians showed different social dignity-diminishing experiences. Twenty Iranian patients, who participated in the study, were excessively concerned with the disclosure of cancer diagnosis. Regarding this concern, the patients were significantly more likely to be obsessed with the fear of being stigmatised by cancer: rejected, judged, pitied, fear of letting others know, and worried that people may think cancer is contagious.

Iranians significantly showed a different emerged theme in terms of images of God. Patients frequently report more punitive images of God which are related to their sense of dignity. The punitive God-image of patients may be rooted in the authoritarian parenting style of their parents, as shown in interviews of eight patients. Other studies also demonstrate that children of controlling and punitive parents have a punishing God-image (Hyde, 1990, p. 96; Potvin et al., 1976, p. 18; Tamminen, 1994, p. 63). Eight patients described they had parents with rigid religious beliefs, one example was "God doesn't love the sinners and not leave sin unpunished". The eight patients came to conclude that they are not deserving of God's mercy, and cancer and its suffering necessarily results from sin.

Conclusion

Overall, the results of this study illustrated how Iranian cancer patients perceive dignity within a very specific collectivist culture. Moreover, this study identified patterns of social and family relations undermining the patients' sense of dignity that are distinct from those in Canada. Although similar findings with Chochinov's (2002) research have been discovered, the results of this study suggest that clinical interventions based on Chochinov's Dignity Model (2002) need to be culturally sensitive for Iranian patients.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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